DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15G798	B. WING		02/28/2014	
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 8424 FANTASIA WAY FORT WAYNE, IN 46809			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
W 000	INITIAL COMMENTS		W 00	00		
W 312	Facility number: 012 Provider number: 156 AIM number: 201 Surveyor: Kathy War The following federal state finding in accord Quality Review compl Shackelford, QIDP.	te licensure survey. lary 25, 26, 27 and 28, 2014. 2577 G798 018530 Inner, QIDP. deficiency also reflects a dance with 460 IAC 9. leted 3/7/14 by Ruth	W 31	12	3/30/14	
	must be used only as client's individual prog specifically towards the elimination of the behare employed. This STANDARD is rabased on record revifailed to include a speplan of reduction for the behaviors and/or sym 2 sampled clients (clients prescribed medication behaviors. Findings include:	ptoms of diagnoses for 2 of ents #1 and #3) who were				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OND NO. 0930-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
		15G798	B. WING		02/28/2014
NAME OF P	ROVIDER OR SUPPLIER		8424	EET ADDRESS, CITY, STATE, ZIP CODE FANTASIA WAY RT WAYNE, IN 46809	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
W 312	dated for December: prescribed Celexa (a depression and Hald schizophrenia. Client (BSP) dated 2/17/14 targeted behaviors of sexual behavior, stea and agitation. Client: #1's] plan of reductio [Client #1] meeting helow. When the below the team will recommended if the team head believes that the reduction be made. It made if the team head believes that the reductione on [Client # elopement to 2 incide months by 8/17/14. December to 1 per months by 2/16/15. December to 2 consecutive months in incidents/month for 62/16/15. Decrease in incidents/month for 68/17/14. Decrease in incidents/ month for 62/16/15. Decrease in aggression to 3 or lesconsecutive months incidents of physical for 6 consecutive months incidents of physic	s Physician's Orders (PO) 2014 indicated he was nti-depressant/anxiety for ol (anti-psychotic) for #1's Behavior Support Plan indicated he had the f, elopement, inappropriate aling, physical aggression #1's BSP indicated "[Client in will be contingent upon is objectives as stated ow objectives are met then itend to the psychiatrist that a The reduction will not be ided by the psychiatrist uction would have a negative 1]. Decrease incidents of ents/month for 6 consecutive Decrease incidents of ents/month for 6 consecutive Decrease inappropriate incidents/month for 6 by 8/17/14. Maintain behavior to 0 consecutive months by cidents of stealing to 5 consecutive months by cidents of stealing to 3 6 consecutive months by cidents of physical as per month for 6 by 8/17/14. Decrease aggression to 1 per month inths by 2/16/15. Client #1's which medication would be	W 312		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G798	B. WING			02/	28/2014
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
AMA				842	24 FANTASIA WAY		
AWS				FO	RT WAYNE, IN 46809		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	iE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
W 312	Continued From page	e 2	W	312			
	dated for December 2	2014 indicated he was					
	prescribed Depakote						
		nd Risperdal (anti-psychotic)					
		ent #3's Behavior Support					
	Plan (BSP) dated 9/1	6/13 indicated "[Client #3's]					
		be contingent upon his					
		s as stated below. When the					
		met then the team will					
	recommend to the ps						
	made. The reduction						
		iatrist believes that the					
		e a negative outcome on					
		al objective #1: Physical 3] will decrease physical					
		to 5 or less each month for					
	••	hs (estimated completion					
		#3] will decrease physical					
		to 2 or less each month for					
	""	hs (estimated completion					
		ioral objective #2: Vocal					
		will decrease vocal outburst					
	incidents to 5 or less						
	consecutive months (estimated completion date					
	3/15/14). [Client #3] v	vill decrease vocal outburst					
	incidents to 2 or less	each month for six					
		estimated completion date					
		objective #3: Inappropriate					
	Sexual Behavior: [Cli						
		incidents to 5 or less each					
		utive months (estimated					
	completion date 3/15						
		te sexual incidents to 2 or					
		six consecutive months					
	1 .	n date 9/15/14). Client #3's which medication would be					
	targeted for possible						
	targeted for possible	reduction.					
		ducted with the Qualified s Professional (QIDP) and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP		
		15G798	B. WING _			02/28/2014	
NAME OF PROVIDER OR SUPPLIER AWS			•	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 FANTASIA WAY FORT WAYNE, IN 46809			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
W 312	the Residential Direc P.M. When asked ab behavior medication,	tor (RD) on 2/28/14 at 3:14 out plans of reduction for the QIDP stated, "I have a it does not list a specific	W 3	12			